The U.S. DREAMS Partnership: Breaking Barriers to HIV Prevention for Adolescent Girls and Young Women

A field report on sexual and reproductive health and rights in the U.S. DREAMS Partnership in Swaziland and Uganda

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The views expressed and conclusions drawn in this report are those of CHANGE.
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In the years since the AIDS crisis peaked in 2005, the progress made through treatment has been nothing short of remarkable. It changed the course of the epidemic. For the first time, more than half of the people with HIV around the world are receiving medication that keeps them healthy and prevents them from infecting others. The number of deaths has been halved. The United States has played a large role in that success. The President’s Emergency Plan for AIDS Relief (PEPFAR), signed into law by President George W. Bush in 2003, has become one of the world’s most effective, dynamic health programs. It has provided access to life-saving antiretroviral treatment for 12.3 million people living with HIV. Treatment offered to pregnant women living with HIV led to the birth of a new generation of children born HIV-free.

Yet, despite all of this good news, it has become increasingly clear that science and medicine are not enough to end the epidemic. Several regions still struggle to reduce new infections. This is especially true in sub-Saharan Africa, where poverty, unemployment, gender inequality, and lack of access to education and adequate healthcare all undermine efforts to reduce HIV infections. Unless these societal and cultural imbalances are more completely addressed, the United Nations’ goal of ending the AIDS epidemic by 2030 could remain out of reach.

To glimpse the dimensions of this looming problem, one need look no farther than that new generation of healthy African children and youth. Nearly two million have been born HIV-free. But the stunning success of that treatment program missed the larger picture of what inevitably will happen when children grow up. Today, adolescent girls and young women remain at disproportionately high risk of contracting HIV. As girls mature to adulthood, they are confronted with efforts to keep them ignorant about their own reproductive health, and cultural practices that force them into early marriage or subject them to sexual violence.

Two years ago, in recognition of the need to address those conditions, PEPFAR again stepped into the breach, this time with a groundbreaking program called DREAMS. Launched in 10 sub-Saharan African countries with the goal to ensure girls could grow up to become Determined, Resilient, Empowered, AIDS-free, Mentored and Safe, DREAMS met with immediate success. In its first year, the program reached one million adolescent girls and young women with a series of programs that provided counseling, mentoring, and access to education and health care, including services to prevent and treat HIV. The DREAMS program also offered job training and financial literacy classes.

At the same time, the United States’ effort in the fight against AIDS continues to pursue ideological policies like the Global Gag Rule and the Anti-Prostitution Loyalty Oath that diminish chances to succeed. These ideological policies miss the in-country realities overseas and inhibit the larger goal of ending the epidemic. The population of adolescent girls and young women disproportionately at risk to HIV infection includes people who inject drugs, incarcerated persons,
the LGBT community, and women and girls living with disabilities. It also includes sex workers. Marginalizing these populations and making it more difficult for at-risk individuals to receive needed health care services will only prolong the epidemic.

For more than two decades, the Center for Health and Gender Equity (CHANGE) has served as a watchdog, holding the U.S. government accountable for its global commitments to advancing women’s health and gender equality. Since PEPFAR’s inception, CHANGE has advocated for PEPFAR funding and policies to address HIV infections among girls and women globally and effectively support sexual and reproductive health and rights. After more than a decade of advocacy, CHANGE welcomes PEPFAR’s increased focus on the societal practices that put this population group at higher risk of HIV infection.

To evaluate DREAMS’ successes and shortcomings, CHANGE staff conducted fact-finding missions to Kenya and South Africa in 2016 and to Uganda and Swaziland in 2017. As in the 2016 report, this report provides a snapshot of how the programs are working from the perspectives of adolescent girls and young women in these countries, civil society organizations, and PEPFAR teams operating on the ground. These collective voices fill out the broader picture of where DREAMS has been successful in preventing new cases of HIV and where improvements are needed.

This candid assessment is especially important as DREAMS reaches a turning point and is absorbed into each Country Operation Plan’s (COPs) core activities in 2018. CHANGE salutes the integration of DREAMS into PEPFAR, as it signals PEPFAR’s recognition of the need to take a broad approach to conquer AIDS. But CHANGE also offers a cautionary note: DREAMS’ holistic purpose must not become diluted or muted once it is integrated into the COPs. DREAMS has moved a step forward toward improving coordination of the global health agenda. It must become part of PEPFAR’s DNA and its partnership with civil society organizations must continue. It operates much of the programming and provide important ties to families and community leaders who have helped to break down those societal barriers that contribute to HIV risk. Our caution reflects the viewpoint of nearly every DREAMS participant the CHANGE staff interviewed.

At CHANGE, we are determined to see the continuation of the gains DREAMS already has made. That progress will go a long way towards renewing hope that the 2030 goal of ending the AIDS epidemic is not just a slogan, but a reality.

Serra Sippel
President
Acronyms

ABC  Abstinence, Be Faithful, and correct and consistent condom use
AIDS  Acquired Immune Deficiency Syndrome
APLO  Anti-Prostitution Loyalty Oath
ART  Antiretroviral Therapy
CSO  Civil Society Organization
CBO  Community-based Organization
COPs  Country Operational Plans
DREAMS  Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
EC  Emergency Contraception
GBV  Gender-based Violence
FSW  Female Sex Worker
HIV  Human Immunodeficiency Virus
IS  Implementation Science
MER  Monitoring, Evaluation, and Reporting
MOH  Ministry of Health
NGO  Nongovernmental Organization
OGAC  U.S. Office of the Global AIDS Coordinator
OVC  Orphans and Vulnerable Children
PEP  Post Exposure Prophylaxis
PEPFAR  President’s Emergency Plan for AIDS Relief
PrEP  Pre-Exposure Prophylaxis
SRHR  Sexual and Reproductive Health and Rights
STI  Sexually-Transmitted Infection
UNAIDS  Joint United Nations Programme on HIV/AIDS
UNFPA  United Nations Population Fund
USAID  United States Agency for International Development
VMMC  Voluntary Medical Male Circumcision
Executive Summary

In the 35-year fight to end the HIV crisis, due in large part to the success of U.S. investments in global health, enough progress has been made to give reason to hope that the global goal of ending the AIDS epidemic by 2030 is within reach. Since 2003, AIDS-related deaths worldwide have decreased 43 percent. In Eastern and Southern Africa, the epidemic’s epicenter, the number of deaths has fallen dramatically, from 760,000 in 2010 to 470,000 in 2015.

Poverty, gender inequality, violence, lack of access to education, teenage pregnancy, and early marriage all converged to keep incidence of HIV infection high.

In spite of these gains, one population group has been largely forgotten: adolescent girls and young women aged 15 to 24. They are disproportionately affected by HIV and account for 74 percent of new HIV infections among adolescents in the region.

Adolescent girls and young women in sub-Saharan Africa have faced a host of societal factors that increased chances they would contract HIV. Poverty, gender inequality, violence, lack of access to education, teenage pregnancy, and early marriage all converged to keep incidence of HIV infection high. But this population has finally received long overdue attention and care. A $385 million groundbreaking partnership, called DREAMS, was specifically created with a comprehensive approach that extends beyond traditional medical treatment for disease to help reduce HIV infections in adolescent girls and young women. DREAMS stands for Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe, and it enlists families, community and religious leaders, young women, and educators to empower girls and young women. Introduced by the President’s Emergency Plan for AIDS Relief (PEPFAR) and launched in 2014 with private partners including the Bill and Melinda Gates Foundation, The Girl Effect, Johnson and Johnson, ViiV Healthcare, and Gilead, DREAMS aims to reduce the incidence of HIV infections in adolescent girls and young women by 40 percent in 10 sub-Saharan African countries by the end of 2017.

Nearly half of all new HIV infections among teenage girls and young women worldwide occur in Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. To assess the DREAMS partnership’s first year of operation as the program was rolled out, CHANGE staff traveled to Kenya and South Africa. Our 2016 report highlighted opportunities as well as the remaining challenges to HIV prevention. We were pleased to see many of the recommendations adopted by PEPFAR. In 2017, DREAMS’ second year, CHANGE staff visited Uganda and Swaziland to look at the lessons learned from the DREAMS interventions and meet with winners of the DREAMS Innovation Challenge, who have created innovative programming to address HIV. This report details our findings and makes recommendations that we believe can and should be implemented.
Methodology

CHANGE conducted an independent 15-day fact-finding mission in May 2017 to Uganda and Swaziland to analyze how DREAMS operates in these countries. Bergen Cooper, Director of Policy Research, and Beirne Roose-Snyder, Director of Public Policy, traveled to central Uganda for interviews between May 15 and 19, and throughout Swaziland for interviews between May 22 and 26.

CHANGE interviewed the following in Uganda, Swaziland, and the United States: civil society organizations (CSOs) that receive DREAMS funding, CSOs that do not receive DREAMS funding, U.S. Missions, PEPFAR gender advisors, the DREAMS interagency team, and adolescent girls and young women in DREAMS programming.

Prior to our travels, CHANGE also issued a request for proposals for two short-term projects that advocate for sexual and reproductive health and rights (SRHR) in Uganda and Swaziland. An important objective of the grants was to encourage civil society engagement in DREAMS, as well as ensure that local women- and girl-led SRHR organizations are able to engage meaningfully throughout the DREAMS implementation process, and that the implementation of DREAMS interventions embraces SRHR integration, particularly contraceptive choice. This includes access to female condoms and other reproductive health commodities. The grants were distributed by CHANGE; they were not administered on behalf of DREAMS.

CHANGE awarded the grants to Alliance of Women Advocating for Change (AWAC) and International Community of Women Living with HIV Eastern Africa (ICWEA) in Uganda and Coordination Assembly of Non-Governmental Organizations (CANGO) in Swaziland. Some of the grantees’ preliminary findings are included in the fact-finding section of this report.

The primary goals in this second DREAMS field report were to assess: ongoing program successes and opportunities, the working relationship between civil society organizations and PEPFAR, use of the female condom, and the inclusion of often-forgotten at-risk populations in DREAMS interventions, including the LGBT community, sex workers, persons with disabilities, prisoners, and people who inject drugs. It was also crucial to gain an early understanding of the impact of the Trump Administration’s expansion of the global gag rule—long known as the Mexico City Policy and now renamed Protecting Life in Global Health Assistance.
CHANGE staff meets with the International Community of Women living with HIV Eastern Africa (ICWEA) in the Wakiso District of Uganda.
A: U.S. GLOBAL AIDS POLICY

The United States has been supporting international health programs for more than a century and is the largest funder of global health programs worldwide. The federal government’s investment to end the AIDS epidemic represents the largest financial commitment by any nation to address a single disease. In 2003, the United States dramatically increased its commitment to the global AIDS fight when, under the leadership of President George W. Bush, the President’s Emergency Plan for AIDS Relief (PEPFAR) was created. By then, AIDS had been declared the leading cause of death in sub-Saharan Africa.

What began as a five year, $15-billion investment to fight HIV/AIDS has been renewed twice and refashioned from an “emergency” program to a sustained strategy to end the epidemic through prevention, treatment, and care. In 2016, 19.5 million people living with HIV worldwide were supported with life-saving antiretroviral treatment, of which nearly 11.5 million were PEPFAR supported. PEPFAR is now widely considered to be one of the most successful global health programs ever undertaken against one of the most challenging health crises of our time.

Sub-Saharan Africa remains the epicenter of the epidemic, home to an estimated 25.6 million people living with HIV as of 2015. Within sub-Saharan Africa, adolescent girls and young women aged 15 to 24 are disproportionately affected by HIV. In 2015, UNAIDS estimated that adolescent girls and young women accounted for 19 percent of new HIV infections globally, and in sub-Saharan Africa, they accounted for 23 percent of new HIV infections. Adolescent girls and young women in sub-Saharan Africa are particularly vulnerable to HIV as they face numerous obstacles to prevention, including social isolation, poverty, gender-based violence (GBV), and limited access to education.

PEPFAR’s broad reach extends across much of the federal government. The agency is managed by the State Department’s Office of Global AIDS Coordinator (OGAC), which is charged with distributing most HIV funding. Monies are parceled out to a host of other agencies working to curb the epidemic, including the U.S. Agency for International Development (USAID), the Centers for Disease Control and Prevention (CDC), the Department of Defense (DOD), and the Peace Corps. As part of its global effort, the United States also contributes funding to a handful of multilateral organizations, including UNAIDS, the International AIDS Vaccine Initiative (IAVI), and the Global Fund to Fight AIDS, Tuberculosis and Malaria, of which the U.S. remains its largest single contributor.

As the world’s largest funder of global health, the United States’ many policies influence the worldwide approach to HIV and AIDS prevention and treatment. On occasion, some of those policies have been misdirected and squandered precious resources on interventions that have been proven ineffective. For example, Congress has required PEPFAR since its inception to promote abstinence and faithfulness as a critical element of prevention programming. Lawmakers eliminated the requirement in 2008, but replaced it with reporting requirements that continued abstinence promotion. The new policy required OGAC to provide congressional justification if PEPFAR programs with generalized epidemics spend less than 50 percent of PEPFAR HIV prevention funds on programs that promote abstinence, delay of sexual debut, and fidelity. This became known as the ABC policy for Abstinence, Be Faithful, and use Condoms.

Between 2004 and 2013, the United States spent $1.4 billion to little effect on PEPFAR programs that promoted sexual abstinence in 14 countries in sub-Saharan Africa. The predictable results of the abstinence campaign were confirmed and documented in a study published in 2016 by researchers at Stanford University School of Medicine. They found no evidence showing that the abstinence policy made any impact on either sexual behavior or reducing new HIV infections. Today, PEPFAR’s DREAMS program guideline is included in PEPFAR’s DREAMS Core Package, which is contained within Preventing HIV in Adolescent Girls and Young Women: Guidance for Country Teams on the DREAMS Partnership (The
Guidance). This expressly states that abstinence-only education cannot be used as a DREAMS intervention.23 While abstinence-only programming cannot be implemented, there is no prohibition on the promotion of abstinence as a prevention strategy if it is included in a comprehensive program that covers all methods of prevention.

Likewise, the United States’ contentious abortion politics have been used to influence foreign assistance for family planning for more than three decades. In 1984, at the 2nd International Conference on Population in Mexico City, the Reagan Administration announced the Mexico City Policy, which, among women’s rights advocates, became known as the global gag rule because it prohibited foreign non-governmental organizations (NGOs) that receive U.S. family planning funds from using their own non-U.S. funds to promote, perform, or advocate for abortion.24 Four presidents that succeeded President Reagan alternately rescinded or reinstated the global gag rule following party lines. President George H.W. Bush continued the policy, President Clinton rescinded it (although it was reinstated for one year), President George W. Bush resurrected it, and President Obama rescinded it again.

Under Trump’s expansion, the global gag rule will apply for the first time to all global health assistance—nearly $9 billion, which includes almost $6 billion in PEPFAR funding.

In making such a sweeping change in funds affected by the global gag rule, the president has put millions of lives at risk. During Bush-era iterations, the global gag rule led to the closing of clinics.26 Trump’s expansion of the gag rule will serve to widen the barriers to health services for women and girls on a global scale.27 Every year, 74 million unintended pregnancies occur in developing countries, leading to an estimated 28 million unplanned births and 36 million abortions.28 Adding PEPFAR for the first time to the gag rule’s restrictions will likely have a similar disastrous effect on PEPFAR’s prevention programs that have helped reduce the rate of new HIV infections.

Most significantly, there has been no evidence that the global gag rule reduces abortions. A Stanford University Study published in the World Health Organization Bulletin indicated a positive correlation between the gag-rule reinstatement and increased abortion rates.29 An assessment of the global gag rule in Ghana showed a correlation between elevated fertility and abortion rates and the decline in access to family planning and reproductive health (FP/RH) services in global gag rule years versus non-global gag rule years.30 What is much more likely to happen is that millions of women in developing countries will lose access to healthcare, according to Marie Stopes International (MSI), one of the largest NGOs that provides women’s health services. MSI operates health clinics in 37 countries and provides family planning, contraception, and abortion services to more than 120 million women. The organization estimates that without alternative funding between 2017 and 2020, Trump’s expanded global gag rule’s application to MSI will result in 6.5 million unintended pregnancies, 2.2 million abortions, 2.1 million unsafe abortions, and 21,700 maternal deaths. It will prevent MSI from providing 1.5 million women with contraception annually.31
The United States also requires organizations receiving PEPFAR funding to comply with the U.S. Anti-Prostitution Loyalty Oath, meaning they must take an official stand opposing prostitution and sex trafficking. In 2013, a decade after the loyalty oath was enacted, the U.S. Supreme Court found it to be unconstitutional. The oath cannot constitutionally apply to U.S.-based organizations, but does apply to any funding that is distributed to non-U.S. based organizations.

**B: THE DREAMS PARTNERSHIP**

On World AIDS Day 2014, the HIV global response took a promising turn. At the White House, PEPFAR’s new DREAMS public-private partnership was unveiled. The program was inspired by the leadership of U.S. Global AIDS Ambassador Dr. Deborah Birx, the U.S. Global AIDS coordinator and special representative for global health diplomacy, who recognized that progress in combating HIV and AIDS lagged far behind among adolescent girls and young women.

In 2014, almost half of all new HIV infections among teenage girls and young women worldwide were concentrated in Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. Young women and girls are still today infected at more than four times the rate of boys the same age.

DREAMS aims to reduce the incidence of HIV among young girls and women in those ten sub-Saharan African countries by 40 percent by the end of 2017. The goal, simply, is to transform girls into Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe women, as the DREAMS acronym suggests.

Although the DREAMS partnership focuses on adolescent girls and young women, the interventions also include three other groups connected to them: male sex partners, families, and the communities in which they live. DREAMS connects adolescent girls and young women to schooling, family counseling, mentoring, and job training, but also identifies and tests their male partners for HIV. The partners may also be referred to clinics for voluntary medical male circumcision (VMMC), a procedure that substantially reduces the risk of female-to-male transmission of HIV. Circumcision has been recommended by the World Health Organization and the United Nations Programme on HIV/AIDS (UNAIDS) since March 2007 in countries with a high prevalence of HIV.

To implement the partnership, DREAMS programs were rolled out using existing PEPFAR partner agencies and NGOs. In its first year, DREAMS reached one million adolescent girls and young women, aged 15-24, with evidence-based interventions. DREAMS stresses the importance of reaching adolescent girls and young women before they are exposed to HIV, and then infuses them with multiple layers of support to enable them to grow into strong, healthy adults.

In 2018, DREAMS will be integrated fully into PEPFAR as one of its core programs—a move that signals its value to reducing the incidence of HIV infections.

To complement DREAMS programming, DREAMS partners invested an additional $85 million to finance innovative approaches that address the complex needs
of adolescent girls and young women. The DREAMS Innovation Challenge, funded by PEPFAR, Janssen Pharmaceutica, NV, one of the Janssen Pharmaceutical Companies of Johnson & Johnson, and ViiV Healthcare, encourages a variety of grassroots and community-led programs for HIV prevention. Grants were awarded to proposals that addressed education, economic empowerment, community leadership, and other societal factors that impact HIV rates. Of more than 800 proposals submitted, 55 winners were selected from all 10 countries, including Uganda, which won 9 grants, and Swaziland, which won one.

Since the launch of the DREAMS partnership in 2014, a number of additional studies have been published that provide additional support for DREAMS-like interventions. These studies showed interventions such as cash transfers, psychosocial care and counseling, both sex and academic education, social support and protection, young women’s empowerment, partner engagement in female condom education, youth-parent communication skills and models, and male and faith-based NGOs’ engagement in SRH helped to curtail the risk of HIV infection in adolescent girls and young women.

Adolescent girls and young women in DREAMS programming through the AVSI Foundation stand outside of class in Mukono, Uganda.
Part II: Background

A: HIV PREVENTION, ADOLESCENT GIRLS, AND U.S. FUNDING IN UGANDA

In 2017, PEPFAR committed $402 million in Uganda for HIV/AIDS-related programs in the ongoing effort to end the AIDS epidemic. Additionally, PEPFAR invested $32 million in Uganda for the first two years of the DREAMS partnership and Uganda’s approved 2017 PEPFAR budget includes another $15.7 million for DREAMS programming next year.

Uganda sits on the equator in East Africa. It is landlocked, although the country contains many lakes, including Lake Victoria, the world’s second-largest freshwater lake. Uganda has one of the world’s youngest and fastest-growing populations. Nearly half of Uganda’s 37 million residents are under the age of 15. Uganda also has a high fertility rate, at 5.8 children per woman, a statistic that reflects cultural or social barriers to contraceptive use and unmet contraceptive needs for family planning.

By 2050, Uganda’s population could climb to 130 million, according to a study by the Population Reference Bureau in Washington, D.C., thereby potentially exacerbating poverty and political instability.

More than 1.5 million Ugandans are estimated to be living with HIV, which is expected to increase to 1.6 million by the end of 2017. Reflecting the larger trend, women are disproportionately affected by HIV. Sixty-six percent of the nation’s new HIV infections occur in adolescent girls. Among young adults between ages 20 and 24, the prevalence of HIV and AIDS is dramatically higher among women than men (7.1 percent versus 2.8 percent). Among people living with HIV, about ten percent are children under the age of 15, and AIDS is the major cause of death of adolescents.

This disparity between men and women is the result, in part, of structural inequalities that PEPFAR and civil society organizations are working to overcome. Enrollment of young women in secondary school is just 22 percent and their enrollment into higher grades is slightly more than four percent. The overall lack of family planning is reflected in pregnancy statistics: nearly a quarter (24 percent) of adolescent girls become pregnant before age 18. More than half of young women aged 15 to 25 have experienced physical violence. Condom usage is low, with only 53 percent of young women in Uganda reporting condom use the last time they had sex.

Nevertheless, Uganda has strengthened its healthcare system, which has enhanced the nation’s ability to respond to the HIV and AIDS epidemic. Uganda is also making progress towards achieving the “90-90-90” plan—which is a UNAIDS goal that, by the year 2020, 90 percent of all people living with HIV will know their status; 90 percent of all people diagnosed with HIV will be on antiretroviral therapy; and 90 percent of the people receiving antiretroviral therapy will have viral suppression.

With the help of PEPFAR-funded programs that are reducing or preventing the number of HIV cases involving transmission of HIV from mother to child, Uganda has achieved the first two “90” goals in children. Among women, Uganda has reached the first “90” goal and is on track to achieve the second “90” goal in the next year. PEPFAR provides more than 890,000 Ugandans with life-saving antiretroviral therapy.
B: HIV PREVENTION, ADOLESCENT GIRLS, AND U.S. FUNDING IN SWAZILAND

PEPFAR committed $10 million to Swaziland for the first two years of DREAMS\textsuperscript{70} and committed $5 million in COP17. Swaziland is one of the smallest countries in Africa and lies in southern Africa, surrounded on three sides by South Africa, which has the largest number (seven million) of people living with HIV and AIDS in the world.\textsuperscript{71} Swaziland, with a population of 1.4 million people,\textsuperscript{72} has the world’s highest prevalence of HIV.\textsuperscript{73} Estimates from July 2017 show that 27 percent of Swaziland’s adult population (aged 15-49) is living with HIV, and, as with Uganda, women are disproportionately affected, with prevalence among women in the 15-49 age group at 34 percent.\textsuperscript{74} Almost a quarter (24 percent) of children under the age of 18 are orphans, and 45 percent are either orphaned or vulnerable.\textsuperscript{74} A vulnerable child is generally defined as one whose life is affected by HIV through the illness of a parent or caretaker.\textsuperscript{76} Swaziland is one of 13 “highest-burden” countries where PEPFAR has accelerated its effort to control the HIV and AIDS epidemic by 2020.\textsuperscript{77}

As they are in Uganda, Swaziland girls are being left behind in education. Enrollment in secondary school stands at 38 percent.\textsuperscript{78} Women and girls experience high rates of gender-based violence and among young women aged 18-24, nearly 38 percent experience sexual violence before they reach the age of 18.\textsuperscript{79}

Opinions among Swaziland’s PEPFAR partners vary about why their tiny nation maintains the world’s highest prevalence of HIV infections, but they strike a common theme. Swaziland has a highly patriarchal system that constrains women’s decision-making abilities.\textsuperscript{80} Condom use, number of children, and contraceptive use are decisions largely made by men.\textsuperscript{81} Men are allowed to marry more than one wife, a custom that may serve as an additional sexual network for transferring HIV.\textsuperscript{82} Progress has been made enrolling girls in secondary school, but getting them to stay in school remains a challenge.\textsuperscript{83} The country remains desperately poor.\textsuperscript{84} In a 2017 study, Oxfam, the anti-poverty confederation of NGOs, named Swaziland as the world’s most unequal nation and gave it poor marks for social programs and progressive taxation.\textsuperscript{85} With few other opportunities, sex work is one way women earn income.\textsuperscript{86} Despite Swaziland’s rankings, July 2017 data shows Swaziland closing in on the goal of controlling its HIV epidemic. Among adults, new HIV infections have been nearly halved, and use of life-saving antiretroviral treatment nearly doubled, reaching more than 80 percent coverage since 2011.\textsuperscript{87} U.S. Ambassador-at-Large Deborah Birx called the findings “unprecedented,” and said they demonstrate that the U.S. government’s efforts to fight AIDS in partnership with African countries now have “a historic opportunity to change the very course of the HIV pandemic.”\textsuperscript{88}

The new data, from the Swaziland HIV Incidence Measurement Survey (SHIMS 2)\textsuperscript{89}—the follow-up to the first national survey to measure HIV incidence through direct observation of new infections—also exposed gaps in HIV treatment and prevention for younger men and women. Adolescent girls and young women (aged 15-24) and men under age 35 were less likely to know their HIV status or receive HIV treatment than older adults.\textsuperscript{90} The DREAMS partnership will continue its work to help reduce HIV infections in adolescent girls and young women and pursue efforts to connect more young men to HIV health services.\textsuperscript{91}

Adolescent girls and young women on a break from a HIV prevention class in Ludzeludze, Swaziland.
A: THE DREAMS PARTNERSHIP AT WORK IN UGANDA AND SWAZILAND

In Uganda, DREAMS programs were implemented in three clusters of high prevalence districts, including: Gulu, Oyam, and Lira in Mid-Northern region; Bukomasimbi, Ssembabule, Rakai in Central 1 region; and Mubende, Mityana, Gomba, and Mukono in Central region.92

Employing multiple layers of programs and services, DREAMS programs are clustered geographically to maintain efficiency.

In Swaziland, DREAMS programs are carried out in 19 of 55 Tinkhundla, or local governments, with a focus on targeted regions to address specific challenges.93 For example, DREAMS is concentrating on education in 14 Tinkhundla, where large numbers of adolescent girls and orphans are not in school, and on helping young women, aged 20-24, and men, aged 20-34. Additionally, DREAMS is focusing on programs in 17 Tinkhundla that draw rural, mobile young adults looking for work on sugar plantations and in the pulp industry.94

FUNDING AND TIMING

In Uganda, the PEPFAR team received word of the new DREAMS initiative toward the end of 2014, according to the in-country PEPFAR team in Kampala. Programs were funded on different schedules, depending on funding cycles for partners and agencies. For example, USAID received DREAMS funding in October of 2015, while the CDC received funding almost six months later. While in many cases, funding lagged, PEPFAR’s existing in-country partners became involved in DREAMS to give the program a fast-track start.

In 2017, the second year of the DREAMS partnership, programs were expanded to three new districts in Uganda.

In Swaziland, the age range of DREAMS participants expanded from 15-24 to include adolescent girls and young women up to age 29.

TARGET GROUPS

An important element of this field research involved assessing whether DREAMS programming would or could be extended to reach several populations with additional risks of HIV infection, including adolescent girls and young women in the LGBT community, incarcerated persons, people who inject drugs, or those who have disabilities. This population also includes sex workers. Although DREAMS guidelines that outline how the program should be carried out do not specifically address the needs of these key groups at risk of HIV infection, the Guidance does not discriminate against their inclusion.95

ADOLESCENT GIRLS AND YOUNG WOMEN WITH SPECIFIC CONCERNS

Fundamentally, the DREAMS partnership is an HIV prevention program, meaning all adolescent girls and young women who are at risk of acquiring HIV are to be included in DREAMS interventions. That includes female sex workers (FSW), lesbian, gay, bisexual, transgender (LGBT) adolescent girls and young women, as well as those with disabilities, those who inject drugs, and those who have recently been released from incarceration.
Except for isolated instances, DREAMS programming does not appear to directly involve any of those population groups in either country, CHANGE learned. While it is certainly possible that some adolescent girls and young women from these groups participate in interventions, they are not explicitly considered in program design. When CHANGE grantee AWAC convened sex worker leaders and groups, they found that not one of the meeting attendees had heard of DREAMS.

On the limited occasions partners do knowingly interact with young women in these population groups, the organizations told CHANGE they try to be inclusive, and also make referrals to programs designed to address their distinctive concerns. That appeared to be particularly true in cases where other funding existed for an intersecting identity or concern. For example, organizations repeatedly mentioned that women who were sex workers would be referred to key populations programs.

Few examples existed of intentionally including or accommodating disability in the programs. A mentor in Swaziland working for a prime partner is deaf and has taken on responsibility for the deaf community in her area. The participation of deaf adolescent girls and young women in the group prompted young women with other disabilities to also join the program.

While adolescent girls and young women living with HIV are not considered a key population, DREAMS continues to grapple with how to include this important group without losing sight of the core prevention goals of the program. Organizations consistently stated that adolescent girls and young women living with HIV who seek out DREAMS are not turned away because they are HIV positive.

B: MEASURING SUCCESS IN EVIDENCE-BASED INTERVENTIONS

The goal to reduce HIV incidence by 40 percent by the end of 2017 had not yet yielded hard data at the time of the writing of this report. But DREAMS partners in both Uganda and Swaziland report that DREAMS interventions are producing qualitative information that suggests DREAMS’ layered, evidence-based approach is succeeding.

Young women or adolescent girls in Uganda who engaged in transactional sex—meaning they trade sex for favors, transportation, or gifts—are showing signs of a shifting balance. After taking part in DREAMS interventions, including mentoring, counseling, assistance to stay in school, and, for those out of school, vocational job training, some girls who spoke to CHANGE are working in jobs such as tailoring and had moved away from the instability of transactional sex. This economic empowerment not only transformed their lives through financial literacy, it also increased their decision-making opportunities. Economic empowerment has been shown to impact HIV by reducing risk factors like transactional sex and intimate partner violence.

Similarly, just arming school children with basic knowledge about their health has helped reduce their risk of contracting HIV. On top of basic course studies in school, which can lead to higher education or employment, CHANGE was told that children are also learning about health in class, including essential details about HIV and AIDS. They have learned about available social support systems that make it easier to report GBV or situations in which their classmates are at risk of leaving school to be married. GBV is associated with HIV high-risk behaviors, which include decreased HIV prevention decision-making abilities like condom use and coercive or forced sexual practices. In the sub-Saharan African context, girls aged 15-19 are two to eight times more at risk for HIV infection than boys in the same age group. In early marriages, child brides have higher risk of HIV infection as they usually marry older, more sexually experienced men and age-disparate relationships have been shown to be a major contributing factor to the epidemic in adolescent girls and young women.
Because DREAMS is a first-of-its-kind approach, positive community response took time. Some adolescent girls and young women who are already married are finding it challenging to join DREAMS when their partners deny them access. CHANGE met with a young partner who was skeptical of DREAMS, but after sitting in on a meeting intended for parents, became enthusiastic about his partner’s involvement in DREAMS. In the first year, some parents in Uganda “pushed back” against DREAMS programming, CHANGE was told, because of initial skepticism about what the programming involved. A year later, when a team member working in a DREAMS-supported agency returned and “bumped into” a graduation ceremony in one of those communities, the doubts had vanished. Parents approached this team member, CHANGE was told, and begged: “Let my daughter join DREAMS.”

**INNOVATION CHALLENGE**

The Innovative Challenge Fund, by design, encourages creative new approaches to HIV prevention for young women and girls. The fund has awarded grants to nine winning proposals in Uganda and just one in Swaziland. CHANGE visited an exciting creative winning program in Uganda—a radio production program operated by the Wizarts Foundation, a nonprofit media organization that produces radio and television programming on social issues.

Wizarts leaders told CHANGE in interviews they were determined to make a difference in the school dropout rate, which is a risk factor for HIV. Girls drop out of school for many reasons—teen pregnancy, early marriage, lack of money to pay school fees. Educating male children is often valued more than female children, and women have little voice and often little community support to continue schooling. But Wizarts leaders noticed accumulating evidence showing that girls who stayed in school had a reduced risk of contracting HIV. So they proposed using Wizarts’ school girls campaign to target the hardest to reach in-school girls and help them stay enrolled.

The program involves multiple parts. Mentors, or “superwomen,” as they are known at Wizarts, coached girls on healthcare, life skills, confidence-building—skills to help them overcome that initial hurdle of self-doubt and persuade them to pursue their dreams. The next steps took place in the recording studios, where the girls wrote and produced short segments that air on four radio stations in the areas where the schools are located and are available within a network of more than 70 radio stations, online platforms, and social media. Wizarts leaders told CHANGE that recruiting parents and community leaders was critical to success in building support for girls, and that the broadcasts provided a way for girls to speak indirectly to their home communities and their families about their lives—something some of them had never done before.

The time in the recording studios was a new and exciting experience. Many of the girls had never seen a microphone until one was handed to them, Wizarts leaders told CHANGE. The girls learned broadcast basics in training sessions. They were also reminded that no one would see them. Their voices alone would tell their stories. The programs followed three different formats. In one segment, the girls described how they perceive society’s views of girls’ lives, such as traditional roles doing housework, and how that affected their ability to stay in school. In another segment, girls wrote essays spelling out their aspirations to become “the girl I want to be.” As a result of the experience, three girls told CHANGE in interviews about their own dreams to become a nurse, an accountant, and a journalist. Finally,
in the last segment, the girls debated societal norms, such as whether boys should also do domestic work to help girls stay in school. Wizarts Innovation Challenge culminated with a gala, described as a local version of the Grammy Awards, where the best performers and essay-writers were recognized. The galas are held every quarter in a different school each time so that each community can have the gala experience.

Wizarts, which launched interventions in five schools in Gomba and four in Gulu, won broad support from schools for its approach, and has been asked to expand the program into additional schools.

Swaziland’s Innovation Challenge winner was World Education, which set up a project aimed at keeping girls enrolled in school in the Fall of 2016. CHANGE learned that the majority of adolescent girls that leave school do so because they are pregnant. Few return, and those who do are required to attend a different school. World Education created two programs, one aimed at getting the teenage mothers back in the classroom, and the other focused on preventing girls from dropping out in the first place. Girls who have given birth attend school on Saturdays. The prevention intervention encourages girls to join clubs operated by World Education, where they can socialize and be mentored and, with that help, gain confidence to continue their education. These interventions, CHANGE learned in the interview, have paid dividends beyond schooling girls. They also have changed attitudes in local communities and helped to create support from community members and families about the value of educating girls, regardless of their circumstances.

ECONOMIC EMPOWERMENT

For girls out of school, vocational training has been well-received in both countries because it often leads to employment, a protective factor for HIV. One Ugandan DREAMS intervention targeted out-of-school adolescent girls and young women, aged 15 to 24, and taught them how to become independent entrepreneurs. Girls chose from a menu of classes that included baking cakes, making soap, paper bags, sandals, or books. Start-up costs were low. Additionally, they received training and mentoring from community business owners. The program also offered additional training in marketing, packaging, and setting prices for their products, as well as teaching them how to keep their accounts. A companion program trained girls to become community health entrepreneurs. They distributed health products such as malaria nets and medications to people in their communities. Sometimes they acted as intermediaries between their community and the government health system. The health program also enabled them to participate in community discussions and forums on HIV and AIDS, reproductive health, and family planning. The skills needed for either intervention were, by design, easy to learn and offered a quick start-up. “We want them to become change agents,” one program manager told CHANGE. “When they start a business … they should also be able to train some of the people in the community. Actually it’s happening right now. There’s a girl who trained her family also in making books so they have a small shop. So it doesn’t end in the girl, but there should be a spillover effect. You’re going to change your community.”
FAMILY PLANNING AND CONTRACEPTIVE SERVICES

Uganda and Swaziland share similar obstacles to family planning access, such as overcoming societal norms that discourage girls and young women from using contraception, as well as unmet need of contraceptive supplies, especially in rural areas. The government of Uganda promotes abstinence-only education through the Presidential Initiative on AIDS Strategy for Communication to Youth (PIASCY), and in 2016, the government instituted a ban on comprehensive sex education. By contrast, Swaziland’s National Policy on Sexual and Reproductive Health stipulates that comprehensive sex education “shall be provided to all children, adolescents, and young people,” and a sex education curriculum is to be provided at both primary and secondary school levels. The value of contraceptive services as a means to reduce the incidence of HIV has been long proven, yet a lack of knowledge on these services still persists in both countries.

In Uganda and Swaziland, modern contraceptive methods that are used include female sterilization, male sterilization, the pill, the intrauterine contraceptive device (IUD), implants, injectables, male condoms, female condoms, emergency contraception, and lactational amenorrhea method (LAM). CHANGE learned in interviews that both countries have limited adolescent-friendly clinics. In Uganda, contraceptives are distributed through government-run clinics as well as private clinics. In Swaziland, since many people know each other and contraception is a difficult subject, girls prefer to obtain contraceptives from DREAMS partner agencies and civil society with experience in youth-friendly services to avoid the prospect of going to a clinic and seeing a nurse who knows their family members.

DREAMS mobile clinics have been set up in all four regions of Swaziland to provide modern health services in rural areas, where such services were previously unavailable. The clinics are popular, even though visiting a mobile clinic can still involve a long walk. CHANGE was told that a young person who has to walk a long distance to obtain a condom is more likely to go without a condom. The adolescent girls and young women we spoke with told us they prefer the mobile clinic as it affords them more anonymity.

Despite these efforts, CHANGE also learned that in both Uganda and Swaziland adolescent girls and young women were still given incomplete counseling for contraceptive services. Just this year, the World Health Organization responded to the growing evidence of a possible increase in risk of HIV acquisition in people who use depot medroxyprogesterone acetate (DMPA) by issuing a Guidance Statement recommending that users be counseled as to the possible risk. CHANGE learned that in most locations in both countries, clinic technicians and providers of contraceptives were unfamiliar with the Guidance or had not incorporated it into their programs.

ACCESS TO PRE-EXPOSURE PROPHYLAXIS (PREP)

PrEP, the daily use of oral antiretroviral medications to prevent HIV infection by HIV-negative people, has been found to significantly reduce the chance of acquiring HIV. Currently, the efficacy of PrEP in women over the age of 18 has shown mixed results that seem to be dependent on adherence. For young women, data from Botswana showed that the greater the adherence to PrEP, the more effective it is. PrEP presents an opportunity for adolescent girls and young women to effectively protect themselves if accessed and used correctly. DREAMS represents the first time PEPFAR included PrEP for adolescent girls and young women in its HIV prevention program.

Both Uganda and Swaziland have been involved in PrEP trials and pilot programs.

In Uganda, according to a 2015 UNAIDS report, where about 200 new infections among adolescent girls occur every week, initial perceptions about PrEP were negative. Policy decision-makers and government officials regarded PrEP as a tool to
promote promiscuity rather than a method to prevent HIV infection. DREAMS civil society partners were credited with helping turn that thinking around, CHANGE learned. One organization had been looking for ways to increase prevention options for girls and young women as a way to slow the rate of new cases of HIV. “These young [HIV] negative adolescents are not living in isolation,” CHANGE was told. “They are living in an environment that is full of HIV. Their colleagues, their peers, their boyfriends, probably around, who are also HIV positive.” The DREAMS program empowered the group to push back against government resistance to PrEP in 2015 when group members first learned about the DREAMS partnership. “The DREAMS initiative helped us to also package our message very well … with policymakers, because we said we can’t continue seeing the number of girls getting HIV infection a week …” CHANGE learned from a PEPFAR in-country team member that the Ugandan political leaders’ change in attitude toward PrEP represents an enormous shift in harmful gender norms by the Ugandan government.

ACCESS TO POST-EXPOSURE PROPHYLAXIS (PEP) AND EMERGENCY CONTRACEPTION (EC)

Post-exposure prophylaxis (PEP) antiretroviral treatment is used to reduce the potential for HIV infection after possible HIV exposure. Emergency contraception (EC) is a form of contraception that prevents pregnancy when taken after unprotected sex. Both PEP and EC are standard care after rape and sexual assault for women and girls and should be taken within 72 hours after unprotected sex. Despite the prevalence of sexual assault and its impact on adolescent girls and young women in both countries, awareness and access of this treatment is very low. Adolescent girls and young women in both Uganda and Swaziland are well informed about PEP, but have little knowledge about EC. The path toward actually receiving the treatment in both countries is unclear.

In Uganda, one prime partner that does not refer school children for either PEP or EC, told CHANGE that counselors teaching sex education in schools are not allowed to talk about EC. Adolescent girls and young women expressed knowledge about PEP, yet they did not know where or when one would get EC. One civil society partner told CHANGE that even information about PEP has yet to saturate the region, especially in rural areas.

CHANGE also learned that it can be more difficult to obtain PEP after engaging in consensual sex, whether unprotected or in situations when condoms failed. National guidelines don’t support the use of PEP for consensual sex, but medication shortages may be a greater driver against requests for PEP after consensual sex than any policy. Although there are instances of Ugandans seeking PEP at clinics after consensual sex, CHANGE was also told that countries with limited supplies cannot, as a practical matter, promote the use of PEP for consensual sex.

GBV is a widespread problem in both countries. In Swaziland, a 2007 UNICEF study reported that about one in three women experiences sexual violence at some point, and almost 56 percent of girls and women who reported any incident of sexual violence prior to the age of 18 experienced two or more incidents in their lifetime. In Uganda, about 22 percent of women aged 15-49 have experienced sexual violence, according to the government’s 2016 Demographic and Health Survey. Yet despite those statistics, in cases of sexual assault, when time becomes essential, opinions differed in Uganda about how difficult it is to obtain treatment. CHANGE was told that adolescent girls and young women who have been assaulted are able to obtain PEP at health facilities without first reporting the incident to police. However, CHANGE was also told they cannot obtain PEP without reporting the incident.

Obtaining PEP in Uganda after sexual assault seems less confusing but more difficult. Adolescent girls and young women are required to report attacks to the police. Police are required to verify attacks before PEP/EC treatment can be dispensed. Not surprisingly, police investigations can consume many hours, and by the time an inquiry concludes, that critical first 72 hours in which PEP is effective has long passed. One
A civil society partner informed CHANGE that rape is sometimes concealed by families and therefore the adolescent girl or young woman is not allowed out of her home to access PEP. Another civil society partner in Uganda informed CHANGE that female sex workers in Uganda are often told after reporting cases to the police that sex workers cannot “be raped” and therefore are unable to access PEP. A female sex worker told the civil society partner that when she went to access PEP from a regional hospital after a condom broke during a consensual sex act with a client, the health worker told her she would have to bring in her client in order to obtain PEP.

In Swaziland, one civil society partner told CHANGE that they intervene in cases of sexual assault, assisting adolescent girls and young women with both the police inquiry and their immediate medical needs, including helping them obtain EC and PEP and other testing.

**PROMOTION AND ACCESS TO MALE AND FEMALE CONDOMS**

The consistent and correct use of male and female condoms is a proven, effective method in preventing HIV infections and unwanted pregnancy. In 2015, USAID procured nearly 10.5 million male condoms and UNFPA procured 1.5 million female condoms for Uganda, while in Swaziland, USAID procured over 25 million male condoms and 146,000 female condoms. Support and availability of female condoms increased significantly in sub-Saharan Africa since 2000. Despite these efforts, female condoms remain less utilized than male condoms in both countries.

According to the 2016 UNAIDS Prevention Gap Report, Swaziland had the second-highest level (after Namibia) of availability of male condoms in the region, and they remain more easily available than female condoms. More than one prime partner told CHANGE that women are discouraged from obtaining condoms (male or female), and that for women, sex as a topic is still taboo. Where there is female condom uptake, they are more popular with women over the age of 30. “I don’t know what we can do as a country to market the female condom,” one civil society partner in Swaziland told CHANGE. “A lot of people who prefer those are above 30. But not the youth. I think we need to do a lot of capacitating when it comes to the female condom use. It’s a women’s empowerment issue.” In Uganda, a civil society partner that provides condoms as part of contraceptive services told CHANGE that despite efforts to provide female condoms in contraceptive packaging, “the uptake is very low.” However, with improved engagement in conversation, girls have been more willing to take female condoms.

DREAMS has sought to change that dynamic with some success; girls and young women told CHANGE they learned about female condoms for the first time from DREAMS and enthusiastically demonstrated how it is inserted. One of PEPFAR’s in-country team members said in an interview that the U.S. government’s approach is “risk avoidance,” supplying the young women with things that would reduce risks. “They need info about condoms, about contraception, and they get that,” the team member said.

CHANGE was informed that some prime partners were implementing the core interventions but leaving out critical lessons on condoms, contraceptives, and sexuality. These partners assured CHANGE that they refer adolescent girls and young women to clinics where they can get condoms. While condoms as commodities can easily be referred, these adolescent girls and young women are potentially missing behavior change interventions that are core to DREAMS.

**ACCESS TO ABORTION**

The protection of SRHR, which includes access to safe abortion, is closely linked with preventing HIV infections. Unwanted pregnancy in both countries continues to be a significant health concern. In 2008, about 1.2 million out of all 2.2 million pregnancies in Uganda were unintended and in Swaziland, the 2006-07 USAID Demographic and Health Survey (DHS) reported about one third of births were from unwanted pregnancies. Globally, preventing 67 million
unintended pregnancies through meeting contraceptive needs would eliminate 25 million induced abortions a year\textsuperscript{136}—of which nearly half are conducted unsafely.\textsuperscript{137} Local laws preventing abortion and the United States global gag rule hinder HIV prevention programs.\textsuperscript{138} Compared to adults, pregnant adolescents are more likely to have unsafe abortions,\textsuperscript{139} which is a serious health concern for adolescent girls and young women in both Uganda and Swaziland. In both countries, DREAMS partners and civil society mentioned it as a driver of poor health outcomes.

Abortion has been legal in the United States since 1973, when the U.S. Supreme Court handed down its landmark decision, \textit{Roe v. Wade}. In the aftermath of \textit{Roe}, Congress passed three amendments to curtail, and then clarify, abortion policies with respect to federal foreign assistance. The Helms amendment, enacted in 1973, states that, “no foreign assistance funds may be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions.” U.S. policy treats Helms as a complete ban on using federal funding for abortion overseas, even for purposes not as a “method of family planning” such as instances of rape, incest, or endangerment to the life of the pregnant woman.

Abortion is mostly illegal in both Uganda and Swaziland, however it is allowable in certain circumstances, which in most cases involve obtaining a physician’s consent. In Uganda, abortion is legal to save the life of the woman.\textsuperscript{140} In Swaziland, abortion is legal in cases of rape, incest, fetal impairment, or physical or mental health of the woman.\textsuperscript{141} In both countries, however, there is confusion about exceptions to the law or how precisely the law is applied. Consequently, large numbers of women seeking abortions do so clandestinely, which often involve unsafe medical procedures that all too often are fatal.

For Swaziland in 2011, unsafe abortions accounted for 37 percent of facility-based maternal deaths.\textsuperscript{142} And for Uganda in 2010, eight percent of maternal deaths were also due to unsafe abortions.\textsuperscript{143} In Swaziland, it is not unusual for women seeking abortion services to travel to neighboring South Africa, where abortion is legal.

**IMPACT OF THE GLOBAL GAG RULE**

President Trump’s reinstatement of the global gag rule and its expansion across U.S. global health assistance has the potential to upend significant progress made in Uganda and Swaziland on health systems integration, HIV prevention, reduction of maternal deaths caused by unsafe abortion, and civil society engagement and advocacy.

Because the maternal health coalition addresses unsafe abortion, groups that receive U.S. funding must now choose whether to continue the important advocacy and accountability project with U.S. funds, which would require them to drop out of the maternal health advocacy coalition.

By extending the global gag rule to PEPFAR, the Trump Administration has impacted programs and relationships with civil society and health providers even in countries with restrictive abortion laws and few provisions for legal abortions, such as Uganda and Swaziland. Since 2014 in Uganda, USAID has been supporting the five-year Advocacy for Better Health project—building CSO and community capacity to monitor supply chains, services, and drug availability—to support government accountability and efficient health systems.\textsuperscript{144} Many of the groups doing work through this grant also participate in an advocacy coalition to end maternal mortality. Because the maternal health coalition addresses unsafe abortion, groups that receive U.S. funding must now choose whether to continue the important advocacy and accountability project with U.S. funds, which would require them to drop out of the maternal health advocacy coalition. The alternative would be to continue their coalition work to advocate for maternal health priorities that includes access to safe abortion, and drop out of Advocacy for Better Health.
In Swaziland, a small country with a limited number of organizations, nearly all stakeholders reported that the Family Life Association of Swaziland (FLAS) is the preferred provider and partner for family planning and other reproductive health services. When the reinstatement and expansion of the global gag rule was announced, organizations assumed that given Swaziland’s restrictive abortion law, and proximity to South Africa where abortion is legal, there would be little impact of the global gag rule in Swaziland. However, FLAS is the International Planned Parenthood Federation affiliate in Swaziland, which will not comply with the global gag rule, and may have to sever partnerships with organizations that receive funding from PEPFAR and other U.S. global health programs. These sorts of expensive and time-consuming analyses of relationships by already under-resourced organizations are pervasive throughout PEPFAR countries, undermining the last decade of U.S.-supported and -integrated, country-owned HIV responses.

The impact that the global gag rule has on partnerships and collaborations in Uganda and Swaziland will be difficult but important to measure. For example, a pregnant woman is often tested for HIV by a health provider at a maternal health or family planning facility. The facility would then provide a referral for the woman to receive HIV treatment from an HIV provider. In fact, prevention of mother to child transmission programs rely on referrals of pregnant women who have tested positive for HIV while seeking maternal or other reproductive health services. Getting these pregnant women and girls into care is vital for their own health and for reducing transmission of HIV to the fetus or newborn. With maternal health and family planning facilities like FLAS being impacted by the global gag rule, these linkages may be severed. Similarly, if the only organization able to distribute large quantities of male and female condoms is ineligible—such as MSI or an IPPF affiliate—there is no plan for stable supplies of condoms for prevention programs. Disruption of these seemingly separate HIV prevention and reproductive health interventions is likely to have impact on the outcomes of DREAMS.

**IMPACT OF THE ANTI-PROSTITUTION LOYALTY OATH (APLO)**

The APLO is a provision in the PEPFAR law that requires all recipients of funding to “have a policy explicitly opposing prostitution and sex trafficking.” In 2013, the Supreme Court of the United States held that the APLO violates the First Amendment of the U.S. Constitution when applied to U.S. based NGOs, since it requires funding recipients to “pledge allegiance to the Government’s policy of eradicating prostitution.” Congress cannot force a grant recipient to “adopt a particular belief as a condition of funding.” To do so, the court ruled, would limit the constitutionally protected right of free speech.

The pledge and the complex application of the court ruling thwarts and, in many cases, negates efforts on the ground in sub-Saharan Africa to provide services to sex workers, who are at high risk of HIV. In some cases, organizations best prepared to work to protect sex workers have been excluded from PEPFAR funding, even though studies show a high success rate of sex worker involvement and leadership in HIV prevention and treatment programs. Conversely, aides in one organization in Uganda told CHANGE they tried to reach out to sex workers, but were not equipped to deal with that population, as it wasn’t their specialty. One organization who works with sex workers told CHANGE that the APLO prohibited them from working on DREAMS. As they noted, young women (aged 18-24) who engage in sex work have not been effectively involved in DREAMS because the very organizations best suited to reach them cannot

FSWs are among the most “at risk” population, and without prevention programs and treatment that is not likely to change.
receive U.S. funding due to the APLO. Funding intended to reach sex workers is funneled through larger U.S.-based organizations that do not necessarily have the community-level presence or an understanding of the nuanced approach to prevention in the sex worker community.

Sex work is illegal in Uganda and Swaziland. While both countries name FSWs as a target population, not a single implementer in either country informed CHANGE that they were directly working with FSWs as a part of DREAMS. FSWs are among the most “at risk” population, and without prevention programs and treatment, that is not likely to change. In Uganda, 16 percent of new HIV infections in 2014 were attributed to sex workers and their clients. The prevalence of HIV among sex workers was estimated to be between 35 and 37 percent that year. In Swaziland, an estimated 70 percent of FSWs are infected with HIV.

Many prime partners providing education, vocational training programs, or basic healthcare services told CHANGE they make health services available to FSWs if they ask for help. But overall, the health needs of sex workers are woefully underserved.

**DREAMS MOVES TO COUNTRY OPERATION PLANS (COPS)**

In 2018, DREAMS will be integrated into each country’s core COP activities. CHANGE found a mixed reaction and opinions in Uganda and Swaziland about that change. Some saw the change as a successful sign that DREAMS will endure as a permanent part of PEPFAR. Others voiced concerns that as PEPFAR absorbs DREAMS, some of its innovative potency could be lost. There were concerns that by moving DREAMS into COP activities, some of the smaller projects funded through the innovation challenge would not continue. As it moves into the COPs, some civil society organizations have expressed concerns that it is an exciting model but expensive to be replicated. Many told the CHANGE team that the two-year sprint to reduce HIV infections in girls and young women by 2017 was unrealistically ambitious. Societal changes of the kind DREAMS seeks take time to occur. No one told CHANGE they want DREAMS to end. They want DREAMS to continue to pursue those ambitions.

The DREAMS acronym is spelled out on a chalkboard in a class where adolescent girls and young women learn how to make reusable sanitary pads in the Gomba District, Uganda.
In multiple ways, DREAMS is chipping away at ingrained societal and economic barriers to young women living the lives that would empower them and protect their health. Against the bulwark of a male-dominated society where girls are pulled from school, married, or pregnant while still children themselves, DREAMS interventions have created opportunities for girls to discover who they are and gain confidence to pursue their own dreams. Educational programs and vocational training in DREAMS takes a holistic approach that not only includes mentoring girls, but facilitating community and religious leaders and parents to broaden their view and become more supportive. These are evidence-based programs, rooted in studies that confirm the link between DREAMS interventions and reduced rates of HIV in girls.

The success of the DREAMS partnership will be measured by the statistical goal of reducing the incidence of HIV. Yet success also can be tracked through the achievements of the young women themselves. For example, CHANGE was told about a Ugandan girl who told her mentor she didn’t know who she was until the mentor helped her set goals. We also learned about a newly minted entrepreneur who joined a DREAMS-sponsored club as an unconfident school dropout and is now financially literate.

As DREAMS is absorbed into PEPFAR’s country operational programming, we look forward to hearing more of these stories. We are, however, carefully watching several parts of the program. First and foremost, we fear that the Trump Administration’s global gag rule will strike a blow to the integrity of DREAMS and upend the advocacy communities that are integral to both ending maternal mortality and ensuring meaningful inclusion of DREAMS in PEPFAR’s core operational programs. The expanded version of the global gag rule could negatively impact advancing the health and rights of women and girls by affecting evidence-driven programs that address reproductive health services (including family planning), including programs that cover HIV/AIDS and/or maternal and child health.

As for the DREAMS partnership itself, we are also concerned that prime partners are tailoring their interventions in ways that leave out crucial lessons on condoms and sexuality.

CHANGE is committed to ensuring the foundation on which DREAMS now rests remains strong. We also offer these actionable recommendations for HIV prevention in adolescent girls and young women:

- Congress and the Administration should fully fund PEPFAR’s engagement in ending the global HIV and AIDS epidemic.
- PEPFAR must fund evidence-based programming consistent with human-rights principles.
- PEPFAR must ensure the knowledge of and availability and access to emergency contraception and post exposure prophylaxis for both circumstances of rape and unprotected sex.
- PEPFAR must monitor and report to Congress on the impact of the global gag rule on HIV prevention, treatment, and care.
- PEPFAR’s HIV prevention programming must continue programming, commodity procurement, and consistent access for male and female condoms.
- PEPFAR must support innovative HIV prevention for adolescent girls and young women as DREAMS programming continues to be folded into COPs.
2 Id. at 2.
7 Kaiser Family Foundation, PEPFAR Fact Sheet, supra note 5, at 10.
9 Kaiser Family Foundation, PEPFAR Fact Sheet, supra note 7, at 1.
14 Id. at 34.
15 Id. at 30.
22 Id.
23 PEPFAR Guidance, supra note 4, at 50.
35 PEPFAR’s private partners include the Bill and Melinda Gates Foundation, Girl Effect (formerly the Nike Foundation), Johnson & Johnson, Gilead Sciences, and Viiv Healthcare. See CHANGE, The U.S. DREAMS Partnership: Breaking Barriers, supra note 5, at 10.
45 PEPFAR’s private partners include the Bill and Melinda Gates Foundation, Girl Effect (formerly the Nike Foundation), Johnson & Johnson, Gilead Sciences, and Viiv Healthcare. See CHANGE, The U.S. DREAMS Partnership: Breaking Barriers, supra note 5, at 10.
47 PEPFAR Guidance, supra note 4, at 25.


See Erin Stern et al., Lessons learned from engaging men in sexual and reproductive health as clients, partners and advocates of change in the Hoima district of Uganda, 17 Cult. Health Sex. S190 (2015).


See Forner et al., School based sex education and HIV prevention in low- and middle-income countries, supra note 45.


UNICEF, A National Study on Violence Against Children and Young Women in Swaziland, supra note 79, at 19.


About CHANGE

The Center for Health and Gender Equity (CHANGE) is a U.S.-based nongovernmental organization that promotes sexual and reproductive health and rights as a means to achieve gender equality and empowerment of all women and girls by shaping public discourse, elevating women’s voices, and influencing U.S. and global policies. We are guided by our vision of a world that respects, protects, and honors sexual and reproductive rights for all. Our four-pronged impact model—advocacy, research, partnership, and communications—is grounded in and driven by a human rights framework at the intersection of multiple sectors including women’s rights, human rights, family planning, maternal health, HIV/AIDS, and gender-based violence.